NUBC Meeting Summary
February 24 & 25, 2003
Baltimore, Maryland
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Conference Calls

- Minutes approved with minor modifications for the following:
  - November 14 & 15, 2002 meeting
  - December 16, 2002 conference call
  - January 15, 2003 conference call
  - February 12, 2003 conference call

  It should be noted that the minutes for NUBC meetings and conference calls are available on the NUBC web site: www.nubc.org

Deferred Coding Requests

- There was a request for national UB codes for states to report mandated surcharges for the variety of reasons deemed necessary by state legislatures.

  Discussion:

  A special work group was charged with the responsibility to investigate the various needs states have to report surcharges. Currently, there are a variety of locally defined UB revenue or value codes. The findings of the work group were that there are two different situations that needed to be addressed by the full NUBC. One in which the surcharges are aggregated by payer while the others are aggregated by the service provided. For the situation that required aggregation by payer, the New York State model of using UB Value Codes was proposed. There already exists electronic support for the service level aggregation in the 4010 version of the 837. There are 2 amount (AMT) fields, service tax amount and facility tax amount. From the discussion, it was not determined where there is a business need to report these surcharges on a paper form. It was also unclear who would use the facility tax in the 837.

  Action:

  The NUBC approved national Value Codes to accommodate the New York State model of surcharges aggregated by payer. There were two sets of codes approved. The assigned Value Codes were consistent with existing codes for Deductible, Co-Insurance, and Estimated Payer Responsibility. Codes AA, BA, CA, EA, FA & GA, AB, BB, CB, EB, FB, GB were two sets of codes defined. Each set supports aggregation for 6 payers. The effective date for these codes is October 16, 2003

- There was a request for national UB Condition Codes to eliminate the need for ambulance attachments and associated manual processes. This proposal was championed by North Carolina.

  Discussion:

  > The requestors re-submitted the original proposal to consolidate some of the state ambulance codes defined for local use in North Carolina to be more generic for national use. One set of the consolidated codes was approved. Another set was tabled because it was unclear whether the proposed condition codes were redundant of existing e-code or HCPCS codes. The requestors were not present at the meeting, so the NUBC was reluctant to assign codes that would replicate current ICD-9-CM or HCPCS classification systems. There were also concerns raised that the proposed UB Condition Codes would not provide a solution for billing professional services. One key question still to be answered by the requestors is what is possible and what is not possible from existing classification systems. Another key question is the impact each proposed solution has on existing ambulance billing systems.

  Action:

  > Condition Codes for "Air Ambulance Required" (AK), "Specialized Treatment / Bed Unavailable" (AL), and "Medically Necessary Stretcher Transport Required" (AM) were approved. All other ambulance code requests were tabled pending further investigation on the suitability of using ICD-9-CM or HCPCS classification systems.

  Public Health Note: This discussion highlighted the importance of being at the standards table to defend requests that are made in person. Without a knowledgeable requestor present to answer questions, the NUBC is rightfully reluctant to approve any new codes when questions arise. The key question for public health and any requestor to sort out prior to a proposal for changes to the UB code set or any other standard is: What is possible and what is not within the current standard? Any effort to promulgate a change to a national standard without fully answering this question will likely be unsuccessful.

New Coding Requests:

- There was a request made by the American Managed Behavioral Healthcare Association (AMBHA) to assign new revenue categories for Community Behavioral Health Program, Group Home, Halfway House, Intensive Outpatient Program, Residential Treatment Acute, and Supervised Living. There was also a request submitted by CMS to add a new patient status code to be defined for

discharges/transfers to psychiatric hospitals and psychiatric district part units of a hospital. The purpose of this new code was to more accurately code these types of discharges on the UB-92.

Discussion:

There was a productive dialog between the NUBC and the requestors. The requestors described the needs and the situations that would be resolved using the requested new revenue categories. The NUBC described the interactions that the revenue codes had with other UB data elements.

Action:

This request and the request for a new patient status code were tabled pending more research on what other codes (i.e. patient status, type of bill) are necessary. Also requesters describe some examples of how the new codes would be used. The requestors agreed to develop less ambiguous definitions of each of the services detailed in the request.

- Listed below is a summary of a series of requests made by CMS
  1. Amend definition for Type of Bill frequency code 0 for when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill.
  2. Delete value O for the Type of Bill frequency code to prevent confusion between this value and value 0 in the same position.
  3. Revise definition of condition code 21, Billing for Denial Notice.
  4. Revise definition of occurrence code 32, Date Beneficiary Notified of Intent to Bill.
  5. Request a new condition code to indicate that the patient was readmitted to SNF after a previous SNF stay, which may or may not have been Medicare covered.
  6. Revise the definition of condition claim change reason code D2.
  7. Revise the definition of condition claim change reason code D4.
  8. Request a new condition claim change reason code E1 to reflect a change in HIPPS codes.

Discussion:

With the exception of request number 4 above, the purpose of each of the requests above was not clearly justified.

Action:

The wording change to correct a mistake in the current definition was approved. All other requests were tabled pending further justification by Medicare.

Coding Issues:

- DRG Coding

  Discussion:

  One of the implementation issues brought to the attention of the NUBC is the reporting of DRG's in ANSI ASC X12 standards. One interpretation of the 4010 standard is that only the Federal DRG would be permissible under the HIPAA mandates, since the code list referred to in the claim (837) and remittance (835) transactions is what is published in the Federal Register. At the current time only the Federal DRG is published in the Federal Register. This is problematic to many states that use DRG groupers that include services not typically reimbursed by Medicare, such as newborn care. The NUBC requested clarification from the Department of Health and Human Services on this matter.

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  Action:

  It was reported that the Medicare program will alter reference in federal register to point to Medicare manual, which will be modified to include DRG groupers other than the current Medicare grouper. It was agreed that the long term solution would be a change to the ANSI ASC X12 standards. The specifics of that long term solution have not yet been developed. The most likely change to the ANSI ASC X12 standards would be to add additional DRG qualifiers to designate other allowable DRG groupers and their code sources, but that is subject to review, comment, and balloting by the X12 organization.

- Definition of Inpatient and Outpatient

  Discussion:

  The claims work group at ANSI ASC X12N is in the process of developing the next implementation guide versions. In developing appropriate situational notes to provide necessary guidance in use of the 837 Institutional claim guide, the NUBC was asked to help clarify the definitions of inpatient and outpatient. The ambiguity in the definitions in these two terms has significant impact on HIPAA compliance for providers. Under HIPAA only outpatient procedures are coded as HCPC / CPT4 codes, and inpatient procedures are coded as ICD-9-CM codes. Without guidance, different payers are applying their own definition to these terms, which then impacts how providers must code procedures. For claims with more than one payer and when any one of the payers disagrees on the definition of inpatient and outpatient, the provider would be forced to double code those records.

The CMS representative distributed the agency's definition of inpatient versus outpatient applicable to Medicare and Medicaid. Members noted that managed care carriers used different criteria based upon reimbursement rates. It also was noted that uniform definitions of inpatient and outpatient are , not routinely applied in actual claim process.

This is counter the intent of the administrative simplification provisions of HIPAA. As a named content committee, the NUBC has been asked to develop guidelines to provide necessary clarification.

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Action:

Though it was agreed that clarifying the difference between inpatient and outpatient would be challenging, it was decided that work would begin to develop consensus definitions. It was also agreed that the results of this work would be published in an industry white paper as a way to educate the industry.

Public Health Note: Though the focus of this discussion centered on the problems for claiming caused by the current ambiguous definitions of inpatient and outpatient, this is an issue of particular interest for public health data systems. The resulting coding inconsistencies cause a significant data quality issue for reporting these encounters to public health. It also highlights the importance of working hard to establish clear definitions that are universally applied by the health care industry.

- State UB Codes

Discussion:

Over the past several NUBC meetings, state Condition, Occurrence, Occurrence Span, and Value Codes have been discussed. The original list of state codes identified to the NUBC was documented in a spreadsheet. This spreadsheet continues to be used as a working document for addressing outstanding state UB coding issues. The goal is to assign national codes to all state defined UB codes. The first priority of the NUBC in addressing state coding issues has been those defined for use by state Medicaid programs.

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Action:

Each state SUBC has been asked to cross check the spreadsheet of needs with the codes that have been approved to date to develop a list of still needed codes. It was agreed that the agenda of the May and August NUBC meeting would give priority to these state requests. It was also

agreed that there be a moratorium on any code request not needed for HIPAA implementation. The NUBC agreed that would be a good idea.

Public Health Note: It is important to remember that there are ranges of UB condition, occurrence, occurrence span, and value codes that have been dedicated for use by public health. The UB codes are very robust and can serve a wide variety of industry needs without having to change the ANSI ASC X12N 837 Claim standard or implementation guides. This same robustness applies to public health use of the Health Care Service Data Reporting Guide. An example of a potential use of a UB code for public health use would be using a condition code to define the Do Not Resuscitate (DNR) order. Please contact your Consortium representatives on the NUBC for help deciding if UB codes could serve any of your unsupported data needs.

DSMO Requests:

- Request Number 735 was approved. This request suggested a wording change in the situational note in the CL1 segment in the 837 Institutional implementation guide.

New NUBC Member:

The Healthcare Financial Management Association (HFMA) was approved for membership on the NUBC. Scott Johnston will serve as the HFMA representative on the NUBC.

Public Health Note: It is important to note that HFMA previously held a voting seat on the NUBC and had chosen to relinquish that seat. Subsequently, the organization realized that was a mistake. It took a couple of years for the NUBC to re-approve NUBC membership to HFMA. This is an important lesson for us in public health. It is important that we continue to participate in the standards process and maintain our hard fought membership rights won through the hard work of the Public Health Data Standards Consortium.

Joint NUBC / NUCC Meeting:

The joint session of the NUBC and NUCC meeting focused on HIPAA issues. DHHS staff updated the two committees. Below is a summary of that report

- Report by Stanley Nachimson from DHHS Office of HIPAA Standards (Responsible for regulations and policies)
  - The regulation for the transactions and codes addenda has been issued. (note: the initial version posted on the Federal Register had some mistakes that were going to be corrected.)
    Addenda Summary

- Ambiguity in some situational notes addressed in the implementation guides
- Some data elements deleted
- The 835 defined as the standard for remittances of pharmacy claims
- The NCPDP standard would be used for pharmacy referrals
- No standard for drug codes, though limited by qualifiers in the X12 HIPAA implementation guides
- October 16, 2003 would be the compliance date for the addenda changes

➢ Security Final Rule Summary
- April 21, 2005 implementation date
- General principles of confidentiality, integrity, and availability only apply to electronic protected health information
- The security matrix defined in the final rule maintains the four procedural areas necessary to secure the data: administrative, physical, data at rest, and data in motion.
- Final rule emphasizes the need for the security measures to be scalable and technology neutral. This is accomplished by putting greater emphasis on risk analysis and documentation tasks in the security matrix.
- The defined tasks in the security matrix in the final rule are either addressable or required.

➢ Status of other rules
- National Provider Id - Final Rule due out this year
- National Plan Id – Notice for Proposed Rule Making (NPRM) due out this year for industry comment
- Attachment – Notice for Proposed Rule Making (NPRM) due out later this year pending additional work being done by the attachment special interest group at HL7.

➢ Report by Laurie Davis from DHHS Office of HIPAA Standards (Responsible for enforcement of everything except privacy rule)
  ➢ Enforcement of all aspects of HIPAA will be complaint driven
  ➢ The enforcement rule promulgated by the Office of HIPAA Standards will be coordinated with the privacy enforcement rule promulgated by the Office of Civil Rights.
  ➢ General philosophy – "separate the hapless from the willful". For the hapless the intent is to help with corrective action plan as part of a good faith effort.

Next Meeting Dates

➢ Note there will be frequent Conference Calls over the next year to address the various state coding issues that stand in the way of HIPAA compliance.
➢ May 7 & 8, 2003 in Chicago, Illinois

- August 5 & 6, 2003 in Baltimore, Maryland
- November 13 & 14, 2003 in Chicago, Illinois